STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING _____ B. WING _____	R 06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the PSR completed on 04/26/12 to the Recertification and State Licensure Survey completed on 02/22/12. This visit was in conjunction with a PSR to the PSR completed on 04/26/12 to the Investigation of Complaint IN00104470 completed on 02/29/12. This visit was in conjunction with a PSR to the PSR completed on 04/26/12 to Complaint IN00104877 completed on 03/09/12. This visit was in conjunction with a PSR to the Investigation of Complaints IN00105519 and IN00106360 completed on 04/26/12. This visit was in conjunction with the Investigation of Complaint IN00110356. Survey dates: June 25, 26, and 27, 2012 Facility number: 010739 Provider number: 155764 AIM number: N/A Survey Team: Regina Sanders, RN, TC Kelly Sizemore, RN (June 25 and 26, 2012) Marcia Mital, RN Sheila Sizemore, RN (June 25 and 27, 2012) Census bed type: SNF: 25 Residential: 71 Total: 96	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155764	A. BUILDING _____ B. WING _____	R 06/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING MILL HEALTH CAMPUS	101 W 87TH AVE MERRILLVILLE, IN 46410

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	Continued From page 1 Census Payor type: Medicare: 17 Other: 79 Total: 96 Sample: 6 Residential Sample: 3 Spring Mill Health Campus was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the PSR to the Recertification and State Licensure Survey. Quality review 6/29/12 by Suzanne Williams, RN	{F 000}		
{F9999}	FINAL OBSERVATIONS	{F9999}		